An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 081

Year: 2025

Inspection Report

Year:	**2025**
Name of Organisation:	**Sherrard House**
Registered Capacity:	**Five young people**
Type of Inspection:	**Unannounced**
Date of inspection:	**20th & 21st of July 2025**
Registration Status:	**Registered from the 31st of July 2025 to the 31st of July 2028**
Inspection Team:	**Eileen Woods** **Lisa Tobin**
Date Report Issued:	**22nd October 2025**

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1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of this centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 31st of July 2001. At the time of this inspection the centre was in its ninth registration and was in year one of the cycle. The centre was registered without attached conditions from 31st July 2025 to 31st July 2028.

The centre was established as a multi-occupancy service, designed to offer short- to medium-term care for up to four young women aged 13 to 17. An additional fifth place was reserved for emergency referrals through the Tusla out-of-hours service. The team adhered to the core principles of this voluntary organisation, focusing on creating a safe, secure, and nurturing environment. This approach aimed to help young people develop trust and build positive life experiences, supported by strong adult relationships and role modelling from the team. At the time of inspection, three young people were residing at the centre and a fourth young person was accessing the emergency place.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
2: Effective Care and Support	2.3
5: Leadership, Governance and Management	5.2
6: Responsive Workforce	6.3

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process.

2. Findings with regard to registration matters

A draft inspection report was issued to the board of management, centre manager and to the relevant social work departments on the 23rd of September 2025. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 1st of October 2025. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 081 without attached conditions from the 31st of July 2025 to the 31st of July 2028 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 8: Accommodation
Regulation 13: Fire Precautions
Regulation 14: Safety Precautions
Regulation 15: Insurance
Regulation 17: Records

Standard 2.3 The residential centre is child centred and homely, and the environment promotes the safety and wellbeing of each child.

This centre is located across two adjoining houses in a city centre location, the facades were subject to a protection order and therefore certain conditions have to be met in replacing or maintaining windows for example. Up to August of 2025 the centre has been under development with a plan to incrementally update significant areas and services within the house over a period of time. Already completed was upgrades to an office, the addition of an outdoor building for recreation purposes and one of two kitchens in the property had renovation completed. The bedroom floors had decorative and other updates completed for the young people and staff. Quotations were being gathered from contractors for bathroom refurbishments. The management had replaced the fire panel and during renovations found that older fire door systems related to a key mechanism were failing and must be replaced. This presents an opportunity for the centre to move to a more modern, safe and functional approach in order to access the exterior of the houses. The centre manager told inspectors that their fire engineer had informed them that the door mechanisms still released automatically in the event of a fire and that the doors themselves were sound in function. The centre management stated that they had tested this and actions were underway to update the door mechanisms. The centre manager must provide the ACIMS with written evidence regarding the ongoing safety of the relevant fire doors and progress regarding the issue.

Inspectors found upon arrival for this unannounced inspection that the centre was clean and well presented but also agree that there are areas requiring ongoing investment and development that had not been possible in recent years due to budgetary restrictions. The signing of an updated service level agreement with Tusla had created an opportunity for the beginning of essential upgrading of the houses.

The bedrooms were being freshened up with scope for the young people to add personal items such as soft furnishings to their rooms during their short-term stays. Inspectors found that consideration has been given to the location of staff, access to bathrooms, access to snacks across the two upper bedrooms floors involving both houses. Inspectors found that where possible the team should include young people's insights into how the house works for them - their comfort, contact with staff and feeling safe within the property for example and take note of this in the planning for the future proofing of the centre. There were a number of sitting rooms with the cosiest being one on the ground floor closest to the staff office.

As stated above some works were ongoing in relation to updating fire systems within the centre and inspectors found evidence of service contracts in place and visits completed by relevant fire safety technicians. There was evidence of staff checks on daily means of escape and other fire safety points, the fire register and another recording folder were utilised and inspectors recommend that fire drills and checks be maintained together in one central location. The staff had completed fire training and there were regular drills completed along with personalised induction into fire exit plans for each of the young people in relation to their room location.

There was an updated safety statement in place, this named the new management team and had been approved by the board of management. The centre staff were trained in first aid to the level set out within the statement. There was insurance in place and accidents and injuries were tracked and recorded. There were health and safety checks completed within the property and these were reviewed by the management team. The risk register tracked environmental risks for the centre, young people and staff. There were maintenance records in place and staff monitored the daily environment to ensure day to day repairs were identified and added to the record. The centre manager outlined a structure for financial compliance in terms of monies available for day to day and emergency works as well as a system of quotations for larger works that would be approved by the board of management. The centre manager named that sourcing a dedicated maintenance service for the centre was underway.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 8** **Regulation 13** **Regulation 14** **Regulation 15** **Regulation 17**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Standard 2.3**
Practices met the required standard in some respects only	**Not all standards under this theme were assessed**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- None identified

Regulation 5: Care Practices and Operational Policies
Regulation 6: Person in Charge

Theme 5: Leadership, Governance and Management

Standard 5.2 The registered provider ensures that the residential centre has effective leadership, governance and management arrangements in place with clear lines of accountability to deliver child-centred, safe and effective care and support.

The centre had undergone a change is centre manager and in deputy manager since the last inspection. This was the first change in many years and the new management team had settled into their new roles, both bringing experience and were qualified for their respective roles. They received inductions from the outgoing manager and deputy manager and were appreciative of their support and advice in the handover period. The centre's purpose and function remained the same and the centre manager had signed a new service level agreement with Tusla. This will be followed by quarterly meetings between the centre and Tusla as the funding body.

There was a board of management in place that met bi-monthly and records evidenced robust board oversight and functions being executed. The board members

were happy with the transition that had taken place to a new management team and noted that good reporting and accountability was being demonstrated throughout. The board were also satisfied with the ongoing developments of the new management structure, team recruitment, the policy development timeframe and the property works.

Inspectors found that the centre manager had structured their governance and oversight through a planned approach and were aiming to implement changes at a pace suited to staff and the young people using the service. They were complementary of the level of experience and work demonstrated by the team and attended handovers and team meetings. The deputy manager attended these forums also and in the centre managers absence they took the leadership role. Inspectors found evidence of tasks being structured and assigned between the centre manager and deputy and audits had been completed from April 2025 onwards. There was oversight and participation demonstrated by the centre manager through the processes referenced and through the governance reporting to the board of management. Given the size of this voluntary body the completion of audits remains an internal process shared by the management team and the social care leaders.

The centre managers quality improvement plan outlined the goals and timeframes for the centre that they had set out. Goals within that included restructuring of the young people's filing system and policy and procedures review. The policy review had a timeframe allocated and the centre manager reported to the board regarding progression with this, the aim was for the review to be completed by the end of October 2025. Inspectors found that the files for young people contained gaps in records, that there was over layering of document types and that the file restructuring project must be prioritised. Inspectors found that due to these issues that it was difficult to track accountability in service delivery for the young people to the fullest extent, a matter raised in previous inspections. Records on file were also not being consistently signed and commented on with regard to feedback on practice and centre registers also required attention.

There was a risk management policy and procedure in place and a matrix had been added for additional range. Inspectors found that a centre risk register was maintained and reviewed monthly, the board received updates on the risks within it and any changes or additions. There were staff and environmental risks recorded on the register and these were generally rated high or very high and did not adjust in line with the control measures. Inspectors recommend that the centre manager considers how they can reflect the positive or likely positive impact of the mitigations and

controls and how these measures manage and reduce risks. There was evidence that some risks were closed when addressed and some were approaching resolution, for example completion rates for training in the centres model of behaviour management had improved.

There were records of young people's risk assessments and plans to manage those risks on file and in an integrated conjoined young people's risk register. These evidenced close collaboration with social workers, guardian ad litums and local child protection gardaí. The social workers informed inspectors that they were very satisfied with the work of the team and the management in supporting the young people, despite multiple challenges and other contributing factors. They noted good communication and reporting taking place and that actions had been put in place that sought to respond to a decline in safety and to seek to improve young people's safety and well-being. Where not successful the measures were reviewed with the team and other professionals. Recent events had required an increased level of security at the centre and any legal issues were known and managed by the board, the centre team and all professionals involved, there were relevant risk assessments in place in relation to this.

Inspectors found areas requiring attention within the risk management records with the young people's risk assessments not evidencing review and updating in line with the format. There was though evidence of good use of one-off dynamic risk assessment as needed by staff. The centre utilised risk assessment to determine the use of restrictive practices and sought to track these. One of the most regularly used measures was separation of the two properties, if they found that risks had escalated between young people, by closing the connecting fire doors. Inspectors found that such measures were not clearly recorded as restrictive practices and did not display timeframes and tracking to ensure that they were managed well and had the intended impact, that being improved or managed safety. Inspectors found that these elements were difficult to track and must be improved. One young person had complained about the house separation and its impact during a one-to-one young person's meeting and this was not processed as a complaint. Whilst the young person and their social worker knew about the house separation and why it had taken place, in not processing the young persons complaint it was a missed opportunity for an examination and review of the measure, its effectiveness and the young person's experience of it.

Compliance with Regulation	
Regulation met	**Regulation 5** **Regulation 6**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 5.2**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre manager must ensure that they prioritise the completion of an updated recording and filing system for the young people's files and that all staff have a training session related to the expected structure.
- The centre management team must ensure that they review, sign and provide feedback on practice within the records completed by staff where relevant.
- The centre manager must ensure that there is review of risk assessments and restrictive practices in line with the format and policies in place.
- The centre management and staff must review the policies on risk assessment, restrictive practices and complaints to ensure that they are delivering on both safety and children's voice being heard in order to inform practice.

Regulation 6: Person in Charge
Regulation 7: Staffing

Theme 6: Responsive Workforce

Standard 6.3 The registered provider ensures that the residential centre supports and supervise their workforce in delivering child-centred, safe and effective care and support.

Inspectors found that there had been some changes on the staff team as well as the management team. Several changes in posts related to promotion within the service, some related to a change to part time work and others had left the service but remained as relief staff. The core of the team were experienced and had long established roles within the centre. There had been some restructuring of roles and staff were on the whole happy with the level of consultation and feedback they had

received as part of this. There were two vacancies coming up on the team and interviews had been taking place during this inspection process, this included forward planning for phases such as maternity leaves. The staff had been using annual leave and breaks as needed and during challenging phases in practice there was recognition of the impact and support was being offered. The team discussed and reviewed how placements had progressed and what had both been successful as well as any additional learning. The team demonstrated their experience in supporting young people at an uncertain time in their life across a range of ages and needs.

The staff safety and well-being was evidenced as well catered for with an employee assistance programme, the health and safety systems in place, training in manual handling and suitable insurance. The risk register noted operational and environmental risks. There was well-being support integrated into supervision and daily practices with a plan to do more social and other positive events for the team. There had been progress on pay and pension rights for staff across the voluntary sector also which was noted as a welcome development. The centre had a weekly team meeting, and the minutes evidenced a focus on learning and development. Staff were being tasked to exercise leadership and identify training opportunities and to take initiative where possible. The team-based approach was being further strengthened through a reintroduction or refreshing of reflective practice, to be reviewed after a period of six weeks.

There was a supervision policy in place and some changes had taken place in the supervision approach to include a performance development plan component. There were certificates provided confirming that the centre manager, deputy manager and two of the social care leaders had received training in the provision of supervision. The policy identified that inductions for staff would include an introduction to supervision and supervision contracts, but records of inductions were absent from the sample of files reviewed. At the time of the inspection the timeframes completed for supervision were not in line with the policy, there was some tracking of this to account for training, annual leave and sick leave with some supplementary supervision sessions also on the record as an interim measure with staff. The sessions did evidence the provision of support and development including some probation records but there was a mix of styles, type of recording and signing and approach still evident. Inspectors recommend that an agreed approach to recording and signing of supervisions notes be put in place.

Compliance with Regulation	
Regulation met	**Regulation 6** **Regulation 7**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards under this theme were assessed**
Practices met the required standard in some respects only	**Standard 6.3**
Practices did not meet the required standard	**Not all standards under this theme were assessed**

Actions required

- The centre management must ensure that they comply with the supervision policy and recording approach to regularise the procedures. Inductions should also be clearly recorded on staff files.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
5	The centre manager must ensure that they prioritise the completion of an updated recording and filing system for the young people's files and that all staff have a training session related to the expected structure.	The centre manager has been maintaining the historic filing system in the centre. A new filing system commenced 01.08.2025 and is physically in place while the existing system is being phased out to the new one. The centre manager is overseeing the implementation of the new system and training for staff is scheduled for October 2025 with completion of all elements and the system active by November 2025.	The development of the new filing system is a quality improvement for the service. All required information for young people is present in the centre. The new system will facilitate ease of use, retrieval and maintenance of young people's files ongoing.
	The centre management team must ensure that they review, sign and provide feedback on practice within the records completed by staff where relevant.	The centre manager provides feedback in daily handovers verbally and in supervision directly with staff. The centre manager will provide written feedback on practice and in documentation ongoing.	Daily review of logs and weekly review of the files for young people will support the centre manager and the deputy manager in their governance and oversight of practice.
	The centre manager must ensure that there is review of risk assessments and restrictive practices in line with the	The risk assessment and restrictive practice procedure is being updated to ensure a robust evaluation of risk is	The review and development of the risk assessment and restrictive practice procedure is a quality improvement for the

	format and policies in place. The centre management and staff must review the policies on risk assessment, restrictive practices and complaints to ensure that they are delivering on both safety and children's voice being heard in order to inform practice.	developed in the centre. The centre manager is managing all risks, and the system will be cohesive in October 2025 to compliment the new filing and care planning system. Currently risks are being assessed through two systems and monitored by the DSCM and SCM. This review of policy will be completed at the team meeting on 30th of September 2025. Training in relation to the policies on risk assessment, restrictive practice and complaints will be complete in training in October 2025.	service. The policy and procedure will be congruent with staff training and support in October 2025. The current transition between systems is being monitored and addressed by the centre manager. Risk assessments, restrictive practice and complaints will be a standing item on team meetings in the centre ongoing. One cohesive risk assessment system and process in line with policy will be operational in November 2025 as part of the new P&P's and filing system.
6	The centre management must ensure that they comply with the supervision policy and recording approach to regularise the procedures. Inductions should also be clearly recorded on staff files.	Supervision training and development have been completed with the deputy manager and social care leaders in September 2025. Recording approaches have been consolidated to regularise the procedure and inductions will be present on all staff files ongoing. SCM has addressed with supervisors that they must record the supervision sessions for supervisee's.	Supervision policy was reviewed in August 2025 and the process and procedures are being agreed with staff in supervision agreements and training in October 2025. This will ensure that supervisors and supervisees are completing supervision in line with policy and procedure.